Alberta Health Services

A literature review of collaborative mechanisms and healthy public policy advocacy

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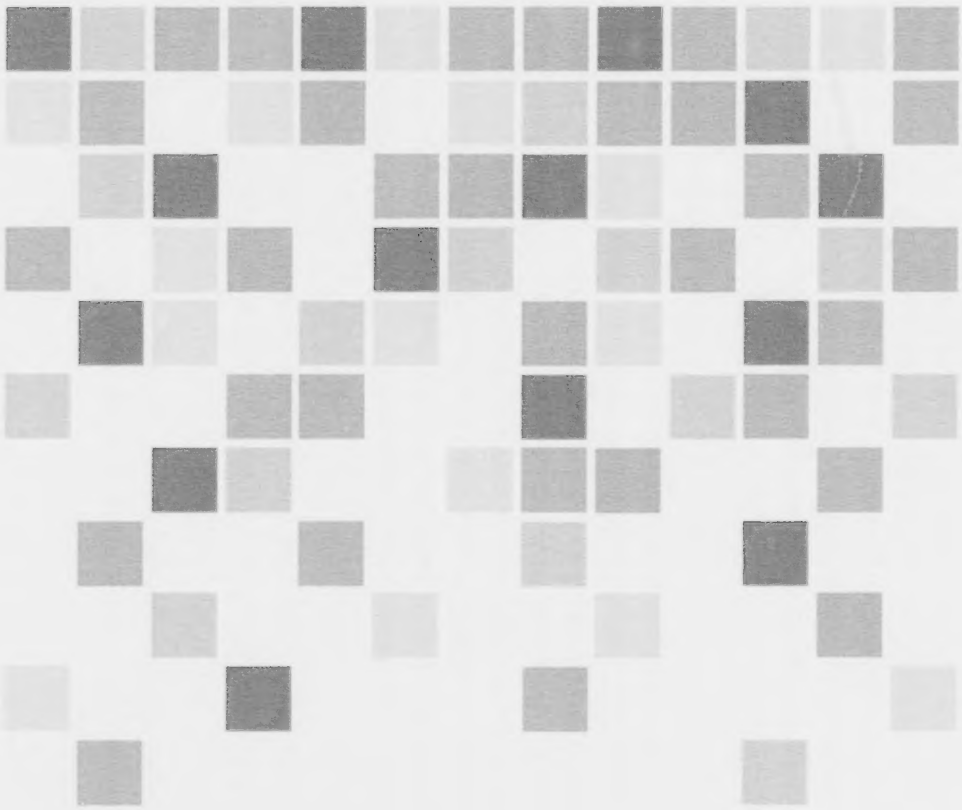

1. Introduction and background

The concept of building healthy public policy was introduced into the health promotion field through the Ottawa Charter for Health Promotion in 1986. Described as "health promotion policy", the Charter recognized the importance of "putting health on the agenda of policy makers in all sectors and at all levels," Soon after, the Adelaide Declaration (1988) expanded on the work of the Ottawa Charter, linking health promotion and healthy public policy:

> Healthy public policy is characterized by an explicit concern for health and equity in all areas of policy and by accountability for health impact. The main aim of healthy public policy is to create a supportive environment to enable people to lead healthy lives. Such policy makes healthy choices possible or easier for citizens.

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The foundation laid out in both documents provides health promotion practitioners with a basis for their work – using an intersectoral and collaborative approach to develop or advocate for healthy public policy. However, public health departments (and practitioners) need to make strategic choices in terms of their involvement with other partners. Furthermore, what are the appropriate collaborative mechanisms and what conditions ensure effective results?

The Healthy Public Policy (HPP) team is positioned in the Health Promotion, Disease and Injury Prevention (HPDIP) Unit of Population and Public Health. HPP is mandated to provide provincial leadership in healthy public policy advocacy.

Given that there are many examples of coalitions and collaborative mechanisms across public and population health in Alberta, the HPP team began examining the evidence on collaboration and possible linkages to advocacy for healthy public policy. The purpose of this literature review is to describe what is meant by "collaborative mechanisms" and how they may support or advance healthy public policy. Although "collaboration" is a term used across many areas, the review focused on key research and discussion papers in the fields of health promotion, population health, and public health.

This literature review builds upon two key background documents familiar to the HPP team.

The first document, entitled *Public Health Advocacy* was prepared by the team in 2009. The report highlights three common elements for public health advocacy: collective action to effect systemic change; a focus on changing upstream factors; and engagement in political processes. The document further states that advocacy requires individual knowledge and skills along with involving a diverse set of stakeholders to address complex problems. Skills include strategic and critical analysis in framing issues, and clear

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articulation of theories of change (e.g. organizational and behavioral change, social movements). Finally, key challenges to public health advocacy are identified, such as objectives that are contested by powerful opponents. The report also recommends the use of developmental evaluation methods given that longer time frames are needed to demonstrate results.

The second background document is *The Core Competencies of Public Health Professionals* developed by the Public Health Agency of Canada (PHAC). This document articulates seven key competencies for public health professionals. The fourth competency specifically identifies *partnerships, collaboration and advocacy*:

> ...captures the competencies required to influence and work with others to improve the health and well-being of the public through the pursuit of a common goal. Partnerships and collaboration optimize performance through shared resources and responsibilities. Advocacy – speaking, writing or acting in favour of a particular cause, policy or group of people – often aims to reduce inequities in health status or access to health services. (PHAC, 2007, p.5)

Four associated competencies are:

1) identify and collaborate with partners in addressing public health issues;
2) use skills such as team-building, negotiation, conflict management and group facilitation to build partnerships;
3) mediate between differing interests in the pursuit of health and well-being, and facilitate the allocation of resources;
4) advocate for healthy public policies and services that promote and protect the health and well-being of individuals and communities.

(PHAC, 2007, p.5)

Both of these documents provide a helpful description which links healthy public policy and collaborative action. Given this background, and the need to explore this idea further, four overarching research questions guided a review of the literature:

1) How are various collaborative mechanisms (e.g., partnerships, alliances, coalitions, networks) defined, and how are their characteristics similar or different?
2) To what extent and in what circumstances are collaborative mechanisms effective in achieving advocacy goals for healthy public policy?
3) Are different mechanisms recommended for various health promotion and disease/injury prevention issues? If so, what mechanisms, and for what issues?
4) What conclusions can be drawn from the literature review with respect to promising practices in healthy public policy advocacy?

The primary audiences for this literature review are the: Healthy Public Policy Team, staff from the Health Promotion, Disease and Injury Prevention Unit, and from Population and Public Health. AHS colleagues working at the Zone public health level may find this information relevant. Secondary audiences would include people working in similar contexts outside of AHS.

2. Methods

A literature search of the Medline and Google Scholar databases was initially conducted in May and June 2010 and updated in 2011. Results were limited to English language studies. The following search terms were used:

- alliances
- cancer prevention
- coalitions
- collaboration
- health promotion
- healthy cities
- healthy communities
- healthy public policy
- heart health
- injury prevention
- intersectoral collaboration
- networks
- partnerships
- policy change
- population health
- public health
- system change
- tobacco reduction

Once relevant articles were reviewed, additional sources of information were found by deliberately following up on references cited.

The following additional questions were used to refine the selection of literature:

- Does the study contribute to understanding collaborative mechanisms used in health promotion (e.g., definitions)?
- Does the study describe the breadth and scope of health promotion issues that use collaborative mechanisms (e.g., tobacco reduction, healthy cities, etc.)?
- Does the study assess policy advocacy and policy change as an outcome measure?
- Does the study describe how policy advocacy is implemented or measured within a multi-strategy intervention?
- Does the study describe the effectiveness or impact of collaborative mechanisms on policy change and/or health outcomes?
- Does the study of collaborative mechanisms on policy change reveal potential facilitating factors and/or barriers?
- Does the study explain the process of building healthy public policy?
- Were the appropriate research design and methods used?

3. Limitations and exclusions

Although this report followed key criteria for inclusion of the literature, it was not designed to be a systematic review of the literature. Thus, it may not be easily replicated based upon the search parameters. This report is a narrative review, which summarizes selected literature.

To narrow the scope of the review, the following areas of collaboration literature were **not** included:

- intra-organizational networks
- community development
- community capacity building
- community/consumer activism
- communities of practice in professional groups
- inter-professional collaboration
- community-based participatory research
- participatory action research
- community engagement
- multi-disciplinary collaboration
- boundary spanning
- knowledge brokering
- mergers
- forced integration
- community-university partnerships

The authors' experience in health promotion and with collaborative mechanisms in organizational, professional, community and intersectoral settings may have influenced the selection and assessment of the literature. Despite the limitations, a logical process was followed to choose, assess, and review the selected literature on collaborative mechanisms in the areas of health promotion, population, and public health.

4. Results

4.1 Definitions and characteristics of collaborative mechanisms

There are many terms for 'collaborative mechanisms' which are used interchangeably. In some cases, terms are used interchangeably within the same article! Below is a compiled list of terms uncovered during our review:

- alliance
- coalition
- collaboration
- collaborative community partnership
- collaborative partnership
- community collaborative
- community health promotion coalition
- community-based teams
- healthy alliance
- horizontal integration
- integration structure
- inter-organizational collaboration

- inter-organizational relations
- intersectoral collaboration network
- joint ventures/joint working
- partnership
- public private partnerships
- strategic relationship
- trans-organizational system

Definitions of collaborative mechanisms (and its related terms) range from practical to more complex in the scholarly literature. Below is a practical "working" definition:

> Collaboration is a mutually beneficial and well-defined relationship entered into by two or more organizations to achieve common goals. The relationship includes a commitment to the relationship and goals; a jointly developed structure and shared responsibility; mutual authority and accountability for success; and sharing of resources and rewards. (Mattessich, et.al., 2001, p. 59)

Hays and his colleagues (2000, p.376) described collaboration as the most complex and formal interaction along a continuum from networking to cooperation to coordination. "Collaboration denotes increased trust and decreased turf protection among members who work together to improve each other's efforts to support and deliver prevention services."

The literature describes different characteristics of collaborative mechanisms which can be arranged in a continuum. The table on the next page entitled: *Terms and Characteristics of Collaborative Mechanisms,* depicts a slice of the conceptual literature.

Table 1: Terms and Characteristics of Collaborative Mechanisms

Reference	Terms and Characteristics				
Frey, Lohmeir, Lee, and Tollefson, 2006	**Networking**	**Cooperation**	**Coordination**	**Coalition**	**Collaboration**
	Aware of organization. Loosely defined roles. Little communication. All decisions made independently.	Provide information. Somewhat defined roles. Formal communication. All decisions made independently.	Share information and resources. Defined roles. Frequent communication. Some shared decision making.	Share ideas. Share resources. Frequent and prioritized communication. All have a vote in decision making.	Members belong to one system. Frequent communication. Mutual trust. Consensus on all decisions.
Bergston, Clark and Hogue, 1995	**Networking**	**Cooperation or Alliance**	**Coordination or Partnership**	**Coalition**	**Collaboration**
	Dialogue & common understanding. Clearinghouse for information. Create base of support.	Match needs and provide coordination. Limit duplication of services. Ensure tasks are done.	Share resources to address common issues. Merge resource base to create something new.	Share ideas and be willing to pull resources from existing systems. Develop commitment for a minimum of 3 yrs	Accomplish shared vision and impact benchmarks. Build interdependent system to address issues and opportunities.
Blickstead, Lester and Shapcott, 2008	**Communication**	**Cooperation**	**Coordination**	**Collaboration**	**Convergence Consolidation**
	Less intense relationships		More intense relationships	Involves a group of independent individuals or organizations working together to achieve a common purpose.	Most intense relationships.
Taylor-Powell, Rossing and Geran, 1998	**Communication**	**Contribution**	**Coordination**	**Cooperation**	**Collaboration**
	Network, round table: Dialogue and common understanding. Clearinghouse for information. Explore common and conflicting interests.	Support Group: Mutual exchange to support each other's efforts. Build mutual obligation and trust.	Task force, council, alliance: Match and coordinate needs, resources, and activities. Limit duplication of services. Adjust current activities for more efficient and effective results.	Partnership, consortium, coalition: Link resources to help parties achieve joint goals. Discover shared interests. Build trust by working together.	Collaborative: Develop shared vision. Build interdependent system to address issues and opportunities. Share resources.

The table is organized according to the level of participation or involvement of members - beginning from the lowest level (left) to the highest level (right). We noted that the characteristics of each term/concept were fairly consistent across the articles we reviewed. Differences between terms related to the intensity of the relationships and the scope of the work undertaken. Dimensions such as the degree of structure, formality, and function, were other variables used to distinguish the terms. (Axelsson and Axelsson, 2006)

For the purpose of our report, the terms used most often are *collaborative mechanisms*, *collaboratives* or *collaboration*.

Various definitions of 'coalition' were also found throughout the literature. It appears that this term is broad enough to embrace a range of structures and relationships. The following definition by Feighery and Rogers (1990) was cited by many researchers: "a coalition is an organization of individuals representing diverse organizations, factions or constituencies who agree to work together in order to achieve a common goal."

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There was also a large body of literature related to using 'networks' in public health. However, the literature pointed out a distinction between networks and coalitions. One definition by Paula Robeson (2009, p.7) stated that:

> Networks are relational organization forms that involve interconnected individuals, groups or organizations within a specific domain of knowledge and practice that interact socially and share knowledge with each other to achieve a common goal.

Robeson further described the purpose of networks as "vehicles for knowledge translation and exchange, organizational knowledge management, work-related behaviour change, professional development, and organizational performance". Despite substantial research on networks, a comprehensive review of several studies by Hill (2002) revealed that policy advocacy was not an explicit goal. The characteristics of coalitions and networks do not speak to the relationships or the scope and complexity of work necessary for building healthy public policy; however, there are a few examples of healthy public policy in the collaboration literature.

4.2 Promising findings for collaborative mechanisms

There was sparse literature on the effectiveness of collaborative mechanisms for healthy public policy advocacy. One explanation that was offered by Kreuter and others stated: "analyses of specific coalition activities suggest that a disproportionate amount of the overall effort seems to be geared to individual-level change and/or to awareness of information, rather than policy or environmental tasks." (Kreuter, Lezin and Young, 2000, p. 55)

Of the total number of articles reviewed on collaboratives for this report, only eight articles specifically mentioned policy advocacy as a strategy of the collaborative. (See Appendix for a summary.) These studies referenced policy advocacy very broadly. However, two studies provided more specific examples: 1) influencing businesses to promote employee assistance programs; and 2) advocating for changes at the local and system level to address the issue of asthma. Unfortunately, these eight studies did not report on the effectiveness of their advocacy efforts.

Eight articles described positive results related to collaboratives that aimed to change policy. Promising examples were drawn from groups working in chronic disease management, as well as alcohol and tobacco addictions. The collaboratives worked

across some or all structural levels - program, community, government, private sector – to change policy and practice. The authors reported varying degrees of success. One large survey reported by Hayes et.al. (2000) revealed that the ability to change policy was positively related to diversity of members and the number of sectors involved. Other articles were not as optimistic or explicit about policy change in their results.

Given that few articles reported on effectiveness of collaborative efforts toward healthy public policy advocacy or policy change, we reviewed the literature linking collaboration to health outcomes to more fully understand the value of collaborative mechanisms used in health promotion and public health fields.

Seven studies reported that collaborative efforts lead to positive health outcomes. In a study by Crowley, Yu and Kaftarian (2000), coalition activities were positively associated with reducing substance abuse behaviour and related health problems in communities. Similar findings were reported in two other community-based studies related to reducing smoking and alcohol use (Collins, 2007, and Flewelling, 2005).

A systematic review conducted by Kuhn, et.al. (1999) found overall positive but modest changes for community-based coalitions that focused on heart health promotion, tobacco use reduction, and injury prevention. Their findings revealed that injury prevention coalitions consistently reported significant results, while heart health and tobacco reduction coalitions reported varied outcomes.

A review of collaborative partnerships found some evidence that associated collaboratives with improvements in population-level outcomes. (Roussos and Fawcett, 2000) The researchers reported that collaboratives showed positive effects with respect to addressing problems of lead poisoning, infant mortality, adolescent pregnancy, and alcohol-related crashes. While they suggested that collaborative partnerships can contribute to widespread change in a variety of health behaviours, the magnitude of these effects were not as great as intended. The article concluded that while all studies reviewed reported improvements in behavior or health outcomes, caution is needed in terms of directly attributing the efforts of collaborative partnerships to these outcomes.

Caution is needed when attributing the efforts of collaborative partnerships to population level-outcomes.

4.3 Conditions and factors influencing successful collaboratives

Although the literature was cautiously optimistic regarding the positive effect of collaboration on improving health outcomes, the research was very rich in describing the conditions and factors associated with successful collaboratives. Most studies were descriptive and presented the results of surveys which revealed the experiences of people involved in collaboratives. The Wilder Collaboration Factors Inventory developed by Mattessich, Murray-Close, & Monsey (2001) is one tool used by many groups to measure progress on collaboration. Granner and Sharpe (2004) also summarized several measurement tools that could be used to evaluate community coalitions.

The factors identified with successful collaborative mechanisms in our literature review were:

- sufficient resources
- community context & readiness
- effective leadership
- participation/commitment of members
- skills/knowledge of members
- shared vision, mission and goals
- evidence-based interventions
- diverse appropriate representation
- appropriate strategies
- social capital/cohesion
- clear roles and responsibilities
- shared power/ownership
- focus on completing tasks/activities
- community engagement/connection
- long term/trusting relationships
- monitoring/evaluation/accountability
- adequate knowledge of health problem
- good communication (internal & external)
- focus on target groups/neighborhoods
- adaptable structure in response to change
- shared/consensus decision-making
- effective conflict management

For more details, please see the matrix of references/factors in Appendix A.

The literature reviewed for this report did not single out or prioritize factors that were essential to effective collaborative mechanisms in health promotion/public health. Most of the factors were related to the collaborative structure although there were a few related to the external environment. The following conditions and factors were reported most frequently in the thirty-three articles we reviewed:

- sufficient resources
- clear roles, responsibilities and structures
- diverse and appropriate representation
- shared vision, mission and goals
- community engagement and connection
- community context and readiness
- effective leadership

Below is a brief synopsis of these seven factors:

Sufficient resources
Of the 33 studies, 23 reported that sufficient financial and human resources are needed to develop, sustain and enhance a collaborative. More specifically, these factors translated into having enough time to plan, implement and evaluate the work; contributing in-kind resources; and, paying someone (a coordinator) who could be dedicated to the collaborative. One systematic review pointed out that existing coalition

research (both strong and weak) is biased toward groups with research and project funding. (Kuhn, et.al., 1999)

Clear roles, responsibilities and structures
Although not generally noted as the most important factors, many researchers (19 articles) acknowledged that clear roles, responsibilities and structures contributed to the success of collaboration. By having a manageable scope of tasks, coordinating the work, and operating within a structure which is "not too complicated", it is possible to advance initiatives. (Bazzoli, et. al., 2003)

Diverse and appropriate representation
To the extent that it is needed, the people involved in a collaborative should represent diverse backgrounds and organizations, including different levels. Improving community health is a complex goal; therefore, diversity can enhance creative solutions and help to align perspectives with the broader community that will be ultimately impacted. (Mitchell & Shortell, 2000) The literature also cautioned that some collaboratives have a large professional membership, which can be problematic. To ensure that decisions are not merely products of narrow organizational, political or special medical interests, Kreuter et.al. (2000) noted that collaboratives should also include appropriate citizen participation.

Shared vision, mission, and goals
In keeping with the importance of an engaged team of representatives, the literature also noted that members should have a shared commitment to the vision, mission and goals. This commitment can lead to a clear direction and focus for the future of the collaborative:

> ...choosing a mission that reflects the needs of the external community, is supported by the community, and is realistic about the resources necessary to achieve the associated goals, is also critical to success...
> (Mitchell and Shortell, 2000, p.249)

Community context and readiness
Thirteen studies highlighted the importance of fit with community readiness and a supportive context. Community readiness can particularly affect formation of the collaborative. Context refers to the characteristics of the ecology/environment that relate to effectiveness of collaboration: physical and structural settings, political climate, policies/laws/regulations, and a history of working together cooperatively. (Bergstrom, Clark, and Hogue, 1995) A community with a history of collaboration will be more likely to succeed than one that has a history of conflict and a lack of trusting relationships.

Several studies questioned whether the poor or modest outcomes of collaborative mechanisms in health promotion were the result of communities asked to work on issues that they had not identified or were not regarded as high priority. (Merzel and D'Afflitti, 2003) One study highlighted that "more than asthma, the people we are working with are worried about getting food on the table, or not getting shot on the way home." (Keirns, 2009, p.S247) In one Healthy Cities initiative (which included an injury

prevention component), the issue of injury did not surface as a key priority area by the community alliances and therefore, people did not become engaged in the initiative. (Green, 2000)

Community engagement and connection
Another community theme highlighted the importance of linking/involving community members with the collaborative group. Some collaboratives engaged whole communities, and included grassroots and civic involvement. Researchers commented that ideally the collaborative structure is not restricted to playing an advisory role, but has an ongoing role to address health promotion and disease and injury prevention. By continually engaging a well-represented collaborative group for input into public health programs, there can potentially be a comprehensive approach to improving the quality of community life and supporting social change. (Merzel & D'Afflitti, 2003)

More than simply connecting and exchanging information, or enhancing one another's capacity, community collaboratives can potentially *advocate* for change. Himmelman (2000) commented that there was limited advocacy for community issues when a large institution (like government) conceptualized, planned, funded, controlled, and evaluated the collaborative. He suggested that local development, in which the collaborative is able to define the issues and solve problems, is a better model.

Effective leadership
While some authors expressed that leadership is simply a part of the well-functioning collaborative group, fifteen articles pointed out that an effective leader guides the development of a shared vision and is able to translate the vision into commonly understood goals for members. Key traits of this leader include being respectful, fair, and focused. (Butterfoss et.al 1998, Goodman et.al., 1998) Bazzoli and her colleagues (2003) pointed out that a valuable leader has "a mix of action-oriented and relationship-building skills".

4.4 Less promising findings for collaborative mechanisms

Given the limited results related to healthy public policy advocacy, a broader look at the literature was needed to understand whether collaborative groups were able to achieve health promotion goals. Bearing in mind that many studies used a quantitative methodological approach, the conclusions were often described as: "null effects, weak, insufficient, or not significant".

Thirteen articles reported less promising findings about the use of collaborative mechanisms in health promotion. (See Appendix for summary.) Although one could simply measure the lack of achievement according to the collaboration success factors discussed in the previous section, specific reasons were articulated by the researchers:

- *Methodological issues with study design.* Some of the problems included: low statistical power, weak design or sampling issues. Speller and others (2005) pointed

out that since health promotion is not able to demonstrate evidence of effectiveness using the established methodology, policy-makers often conclude that the lack of effectiveness equates to no effect at all. Many scholars commented on the importance of better quality research to inform whether collaborative mechanisms can make a difference. There have been examples of strong research-policy collaborations using participatory action research methods. While this may be a promising way of studying the effectiveness for healthy public policy advocacy, it also suggests the importance of engaging researchers, policymakers, practitioners and funders on issues of common concern. (Speller, et.al, 2005)

- *Limitations related to the intervention.* In some cases the interventions were limited in duration, insufficient in scope, or did not penetrate into the community and failed to achieve population-wide results. (Merzel & D'Afflitti, 2003)

- *Lack of effective governance and management.* This situation resulted in poor alignment between the internal operations (that is, goals, strategies, structures) of the collaborative and the demands of the external environment, specifically, with respect to community capacity, political system and social system. (Mitchell & Shortell, 2000)

- *Complexity of planning tasks.* Although the collaborative may have good intentions, if the preliminary work and documentation was not sufficient, rigorous or useful, the collaborative did not survive. (Kreuter et.al., 2000)

- *Conflict in partnerships with public health.* Kreuter and his team (2000) noted that problems with adequate public health infrastructure affected the functioning of collaborative mechanisms. Unfortunately, this finding is relevant for many jurisdictions today.

- *Unrealistic expectations regarding outcomes.* To meet the demands of accountability, there is a desire to demonstrate short term success and measurable results, particularly for business-oriented stakeholders. However, changes in population health status are not easily measured in the short term, and nor is there a cause-and-effect relationship between the collaborative's activities to longer term outcomes. (Butterfoss and Francisco, 2004, and Kreuter et.al., 2000)

5. Summary and conclusions

Many people have generally accepted that building healthy public policy requires advocacy, and advocacy requires collaboration in order to place health on the agenda of policy makers. Given the emphasis and growth of using collaboratives in health promotion initiatives, the Healthy Public Policy team conducted a descriptive review of the literature to determine the relationship between collaborative mechanisms and healthy public policy advocacy.

At the beginning of this report, we identified four questions to guide our literature review. We have posed each question again, followed by a brief description of our conclusions.

1. What is the definition of "collaborative mechanisms" and what are the important characteristics?

   We reviewed many terms and definitions used to describe collaboration in the fields of health promotion, disease and injury prevention; these terms are used interchangeably even within the same article! Collaboration is generally described as a mutually beneficial and well-defined relationship between two or more organizations to achieve common goals. Conceptually, there is continuum of collaboration based upon variables such as the scope and complexity of the issues, and the intensity of the relationships.

   Many studies have focused on success factors for building and maintaining collaborative mechanisms. Seven process and contextual factors emerged strongly from this review:
   - Sufficient resources - human, financial, and time
   - Diverse and appropriate representation
   - Clear and manageable roles, responsibilities and structures
   - Existence of a shared vision, mission and goals
   - Fit with community context and readiness
   - Engagement/connection with the community
   - Effective leadership

2. To what extent, and under what circumstances are collaborative mechanisms effective for healthy public policy advocacy?

   Unfortunately, there were few published studies that reported on the effectiveness of using collaboration for advocacy of healthy public policy. Promising examples were highlighted for the management of asthma, as well as alcohol and tobacco addiction. One large study highlighted that the ability to change policy was positively related to the diversity of members and the number of sectors involved.

3. Are different collaborative mechanisms recommended for various health promotion and disease/injury prevention issues? If so, what mechanisms and for what issues?

   There were no clear recommendations for collaborative mechanisms for issues related promotion/prevention. Many studies focused on successful collaboration as the key outcome rather than resolving the health issue. In reference to the broader collaboration literature, we noted that function or purpose of a collaborative mechanism needs to be clear in order to develop an appropriate structure. Loosely formed networks are purported to be an appropriate structure for the main purpose of knowledge exchange, whereas more intensive collaboration is needed to address complex, interdependent action (such as policy advocacy).

4. What conclusions can be drawn from the literature with respect to promising practices in healthy public policy advocacy?

   While the importance of advocating for healthy public policy is highlighted in key health promotion and public health reports, promising practices are not well documented. Collaborative mechanisms (and its many other names) are proposed as *one* way to advocate and influence change in public policy for improving the health of the population.

6. Implications

Given the considerable research related to collaborative mechanisms and smaller body of work specifically related to healthy public policy advocacy, what do the findings mean in practice?

- There is a continuum of meaning for collaboration which is useful in understanding how a group functions. In addition, the level of collaboration within a group could affect whether advocacy for healthy public policy is even plausible.
- There is limited research that associates successful policy advocacy with collaboration in the health promotion arena. Given the results, collaboration may be an enabler but it could also be a barrier to achieving policy change.
- Collaboration may be *one way* to influence policy, which could in turn, improve population health. However, not all collaboratives have the goal of policy change.
- Healthy public policy advocacy involves engaging in political processes, which typically involves collaborative effort.

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Appendix A: Summary of Selected Literature

Figure 1: Literature that described the action or goal of policy advocacy

Reference	Key findings
Butterfoss & Francisco (2004)	Community partnerships and coalitions can inform policy decisions.
Butterfoss & Kegler (2002)	Community coalitions may enable healthy public policy and legislation.
Cohen et.al.(2002)	Described an eight step guide to coalition development. At the very extreme end of the spectrum of primary prevention is "influencing policy and legislation". Example: environmental change is important to injury prevention, which is brought about by advocating for policy and legislation.
Fawcett et.al. (2006)	Collaboratives can bring about community and systems change through new/modified programs, practices and policies. Examples of enabling policy: increased fines for selling illegal products to minors, family-friendly policies in business
Goodman et.al (1996)	Presented a socio-ecological model of a coalition which includes public policy among other factors. Suggested that policy change is a way for coalitions to create lasting changes for prevention of substance abuse and related risks. Recommended using a case study approach to evaluate the complexity of a community coalition.
Keirns (2009)	Community based coalitions have helped to broaden the debate on asthma beyond individual, clinical care and education, to social and environmental justice. Described two types of coalitions: 1) sufferers, families and their communities participate in advocacy, policy work and research. 2) asthma advocacy organizations use consumer action, government regulation, and public pressure to increase access to treatment, improve housing conditions, and decrease pollution.
Mitchell & Shortell (2000)	Maintaining linkages outside the collaborative is important for financial purposes and when the goals are policy making and system change. The authors also reported that if the collaborative has a 'central' position in the power structure of a community, it will have greater influence/input on issues.
Weibel (2006)	Described an advocacy coalition framework for understanding stakeholders and political context. Suggested that it is unlikely scientific evidence alone will lead to belief or policy change.

Figure 2: Literature that reported changes to policy

Reference	Key results
Clark et.al. (2010)	There were 89 policy and system changes, and improved health outcomes achieved related to the coalition efforts of "Allies Against Asthma".
Emshoff et.al (2007)	A survey of 157 collaboratives in Georgia found systems change (radiating change from the collaborative itself) was reported mostly in first year, in groups with more activity, and where the chairs had longer tenure. The indices of system change increased consistently over the first 3 years, but were less consistent in later years.
Goldstein, et.al. (2010)	Coalition based advocacy strategy was successful in the passing of fire-safe cigarette legislation.
Hays et.al. (2000)	28 coalitions focusing on substance abuse in youth were surveyed. Results indicated that a change in policy was positively related to coalition factors of member diversity, and sectoral representation. The coalition factors of leadership and member participation were not significantly related to policy change.
Meister & Guersney de Zapien (2005)	Two community coalitions involved in policy and advocacy were able to document changes in local policies and practices related to the coalition activities, ranging from new walking paths to promoting healthy products at local grocery stores.
Rose et.al. (2003)	Some community planning groups (coalitions)for HIV prevention were involved in policy development and systems change. Just over half of members surveyed indicated there were policy changes during the years studied. More than half of the members perceived that the coalition changed the outcome of funding distributions.
Wagenaar et.al. (2000)	7 community coalitions were focused on reducing youth commercial and social access to alcohol. The communities that successfully changed community policy and practices to reduce access to alcohol reported declines in arrests and traffic crash indicators.

Figure 3: Literature that reported collaboration associated with positive health outcomes

Reference	Key findings
Burnes Bolton et.al. (1998)	The infant mortality rate for African Americans in Los Angeles County declined significantly after four years, associated with collaboration among health professionals, media, elected officials, and community leaders.
Collie-Akers et.al. (2007)	The Kansas City Chronic Disease Coalition was effective as a catalyst for change by helping create the conditions for improved the health behaviors. The study speculated that these positive changes would eventually lead to improved health outcomes of community residents."
Collins et.al. (2007)	At meta-analysis study revealed that there were small reductions in cigarette use, alcohol and binge drinking among youth, attributed to the work of community coalitions in Kentucky.
Crowley et.al. (2000)	In a study related to reduction of substance abuse behaviours in communities, there was a positive relationship between the coalition's prevention activities and health-related outcomes.
Feinburg et.al. (2007)	Communities that employed the 'Communities that Care' coalition model had lower rates of some risk factors and problem behaviours related to adolescent substance abuse than communities not using the model.
Findley et.al. (2008)	'Start Right', a community coalition driven immunization program, showed significantly higher immunization coverage rates than the control group.
Flewelling et.al. (2005)	Across the communities served by the coalitions, greater reductions in student substance use (drugs, alcohol, tobacco) were achieved for all nine measures examined.

Figure 4: Literature that reported no change/inconclusive findings associated with collaborative mechanisms

Reference	Key findings
Berkowitz (2001)	A review of evidence reported that community-based coalitions showed: weak outcomes, contradictory results, null effects, marginal evidence of success, and inconclusive at best.
Butterfoss & Francisco (2004)	The research does not support strong conclusions about the impact of community partnerships and coalitions on population level outcomes such changes in health status.
Butterfoss et.al.(1993)	Coalitions for prevention and health promotion have not been studied in an organized and systematic way; relatively little empirical evidence supports their effectiveness.
Collins et.al.(2007)	Results showed no significant reduction in prevalence of substance abuse and actually an increase one type of substance use (inhalants).
Drach-Zahavy & Baron-Epel (2006)	Very few coalitions were engaged in policymaking and reforms; therefore it was not possible to analyze or draw conclusions about effectiveness in this area.
Feinberg, et al. (2007)	Findings revealed that the 14 coalitions or partnerships did not show significant effects on community measures.
Green & Kreuter (2002)	Heart health, cancer, and smoking cessation initiatives of the '90s "did scarcely better and possibly worse than the comparison communities".
Hallfors et.al (2002)	Results showed there were no effects on community and youth goals related to reducing substance abuse. Coalitions that targeted adults actually did worse on related indicators over time compared to matched controls.
Klerman et.al (2005)	The researchers stated that they had serious reservations about using the Communities That Care coalition biased approach for the complex issue of teen pregnancy.
Kreuter et.al. (2000)[3]	Collaborative mechanisms did not report any change/effect due to: high early failure rate, complexity of planning tasks, partnerships with public health are conflict ridden, costs outweigh benefits, unrealistic expectations or outcomes, lack of clarity around intermediate outcome as a precursor to long term health outcomes.
Merzel & D'Afflitti (2003)	9 of 17 interventions studied included explicit policy advocacy (or regulatory) activities (reducing tobacco, alcohol, drugs). The initiatives focused activities at the individual level (e.g. media campaigns, work with local merchants) not at the population level.
Rosales et.al, (2010)	This case study of a diabetes prevention coalition did not report any change on health outcomes. Most respondents still felt their community was still having the same problems prior to the presence of the coalition.
Roussos & Fawcett (2000)	Findings were insufficient to make strong conclusions about the effects of partnerships on population-level outcomes. Most of the research was conducted as case studies which had threats to internal and external validity.
Socolar (2002)	It is unclear whether collaboration is the goal or the means. As a result there is conflicting evidence about whether collaboration is effective in achieving the desired results, such as health outcomes. Given limited resources, there needs to be better evidence about outcomes related to collaboration.

Appendix B: Success Factors for Collaborative Mechanisms

Literature that reported success factors for collaborative mechanisms

SUCCESSFUL COLLABORATION FACTORS	Total Frequency	Bazzoli et.al	Bergstrom et.al	Blickstead et.al	Butterfoss & Francisco	Clark et.al	Cohen et.al	Drach-Zahavy & Baron-Opel	Easterling	Fawcett et.al	Feinberg et.al 2004	Feinberg et. al. 2007	Florin et.al	Gillies	Goldstein et.al	Goodman et.al	Green J
Sufficient resources – financial/human/time	22	■	■	■	■	■	■		■	■			■		■	■	■
Clear roles/responsibilities/structures	19	■	■	■			■	■	■		■			■		■	■
Diverse & appropriate representation	18			■		■	■	■	■					■	■		■
Shared vision, mission, goals	18		■	■	■	■	■			■		■		■	■		
Community engagement/connection	18		■		■	■		■	■	■			■	■	■		■
Community context & readiness	17	■	■		■		■		■		■	■			■	■	
Effective leadership	17	■	■	■	■				■	■	■				■		■
Strategic /action oriented plans	16	■			■				■	■			■	■		■	■
Skills/knowledge of members	15						■			■	■	■	■		■	■	
Participation/commitment of members	14			■	■	■	■	■			■	■	■				■
Attention to monitoring/evaluation/accountability	12		■	■	■	■	■			■						■	
Using evidence-informed interventions	11											■				■	■
Strength of social capital/cohesion	8											■		■		■	
Consensus/shared decision-making	7		■			■	■		■	■							
Effective communication - internal & external	7		■							■		■			■		
Adequate knowledge of health problem	6			■								■					■
Long term/ trusting relationships	6		■	■													
Favorable political/social environment	5		■												■		
Focus on completing priorities/tasks	5	■					■						■		■		
Shared power/ownership	5						■							■			
Organizational context/support	4																■
History of working together	3		■														
Effective conflict management	3	■									■						
Focus on neighborhoods/target groups	2					■											
Adaptable in response to change	2	■															

Literature that reported success factors for collaborative mechanisms (con't)

COLLABORATION FACTORS	Green & Kreuter	Hallfors et.al.	Hays et.al	Kuhn et.al	Loue	McLeroy et.al	Meister & Guersney de Zap ien	Mitchell & Shortell	Padgett	Rose et.al.	Roussos & Fawcett	Shortell et.al	Spoth et.al	Valente et.al	Wells et.al	Wolfe	Zakocs & Edwards
Sufficient resources -financial/human/time	■	■		■	■	■		■	■	■	■	■	■				
Clear roles/responsibilities/ structures				■	■			■	■	■		■		■	■		■
Diverse & appropriate representation			■		■			■	■	■	■	■		■		■	■
Shared vision /mission/goals		■		■	■			■	■		■	■		■		■	
Community context/readiness				■	■	■	■	■	■		■					■	
Community engagement/connection	■	■	■	■		■					■	■				■	
Effective leadership			■						■	■	■	■		■	■		■
Strategic/action-oriented plans		■	■			■	■	■	■		■	■					
Skills/knowledge of members	■			■	■	■			■		■			■		■	
Participation/commitment of members			■			■			■						■		■
Attention to monitoring/evaluation/accountability		■						■			■	■				■	
Effective communication (internal & external)											■	■	■				
Using evidence informed interventions	■	■	■	■		■					■		■	■			
Strength of social capital/cohesion					■	■	■				■						■
Consensus/shared decision-making												■				■	
Adequate knowledge of health problem				■		■		■									
Long term/ trusting relationships				■			■		■			■					
Favorable political/social environment						■					■					■	
Focus on completing priorities/tasks												■					
Shared power/ownership							■		■						■		
Organizational context/support									■	■							■
History of working together						■		■									
Effective conflict management												■					
Focus on neighborhoods/specific target groups				■													
Adaptable in response to change												■					

Figure 4: Literature that reported no change/inconclusive findings associated with collaborative mechanisms

Reference	Key findings
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[2]Green & Kreuter (2002)	Heart health, cancer, and smoking cessation initiatives of the '90s "did scarcely better and possibly worse than the comparison communities".
Hallfors et.al (2002)	Results showed there were no effects on community and youth goals related to reducing substance abuse. Coalitions that targeted adults actually did worse on related indicators over time compared to matched controls.
Klerman et.al (2005)	The researchers stated that they had serious reservations about using the Communities That Care coalition biased approach for the complex issue of teen pregnancy.
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[4]Merzel & D'Afflitti (2003)	9 of 17 interventions studied included explicit policy advocacy (or regulatory) activities (reducing tobacco, alcohol, drugs). The initiatives focused activities at the individual level (e.g. media campaigns, work with local merchants) not at the population level.
[5]Rosales et.al, (2010)	This case study of a diabetes prevention coalition did not report any change on health outcomes. Most respondents still felt their community was still having the same problems prior to the presence of the coalition.
[6]Roussos & Fawcett (2000)	Findings were insufficient to make strong conclusions about the effects of partnerships on population-level outcomes. Most of the research was conducted as case studies which had threats to internal and external validity.
[7]Socolar (2002)	It is unclear whether collaboration is the goal or the means. As a result there is conflicting evidence about whether collaboration is effective in achieving the desired results, such as health outcomes. Given limited resources, there needs to be better evidence about outcomes related to collaboration.

1. Drach-Zahavy, A. and O. Baron-Epel, *Health promotion teams' effectiveness: A structural perspective from Israel.* Health Promotion International. **21**(3): p. 181-90.
2. Green, L. and M. Kreuter, *Fighting back or fighting themselves? Community coalitions against substance abuse and their use of best practices.* American Journal of Preventive Medicine. **23**(4): p. 303-306.
3. Kreuter, M., N. Lezin, and L. Young, *Evaluating community-based collaborative mechanisms: Implications for practitioners.* Health Promotion Practice. **1**(1): p. 49-63.
4. Merzel, C. and J. D'Afflitti, *Reconsidering community-based health promotion: Promise, performance and potential.* American Journal of Public Health. **93**(4): p. 557-573.
5. Rosales, C., et al., *The culture of health survey: A qualitative assessment of a diabetes prevention coalition.* Journal of Community Health. **35**: p. 4-9.
6. Roussos, S. and S. Fawcett, *A review of collaborative partnerships as a strategy for improving community health.* Annual Review of Public Health. **21**: p. 369-402.
7. Socolar, R., *Collaboration: The end or the means?* Journal of Public Health Management & Practice. **8**(1): p. 34-35.